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Testimony to the Kansas Health Policy Authority

July 11, 2006

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Madam Chair, members of the Kansas Health Policy Authority, and Dr. Nielson, my name is Pete Zevenbergen, I am the Executive Director of Wyandot Center for Community Behavioral Health located here in Kansas City. My comments today are not only on behalf of the Association of Community Mental Health Centers of Kansas, Inc., but also reflect some of my own insights as a health care provider.

Recognizing your responsibility for the development of a statewide health policy agenda including health care, health promotion and health indicators, I hope you will find what I have to share with you today useful in fulfilling that responsibility.

I would like to begin by applauding efforts such as the Business Health Policy Committee, which is looking to increase the financial incentives available to small businesses when they decide to offer health insurance to employees; the Community Rx Kansas program, designed to provide low-income, uninsured Kansans access to affordable prescriptions; and Community Health Record, a piloted use of an electronic health record. These three examples represent an excellent start to begin addressing affordable health care for Kansans.

While we have had the opportunity for some limited dialogue with Connie Hubbell and Dr. Nielson in recent months around the topic of mental health and the Kansas public mental health system, this is the first opportunity we have had to appear before the entire Authority. Rather than consume my time before you today discussing the public mental health system, I have included with my testimony several attachments to serve as educational tools for you: Attachment A – CMHC Snapshot; Attachment B – Consumer Success Stories; Attachment C – Risk and Protective Factors; and Attachment D – Transformation Grid.

I would also like to share with you separately a copy of a report published by the Association in March of this year, "How Kansas Stacks Up: A Regional and National Comparison of Mental Health Care Services." This document will give you some sense of how Kansas compares to its surrounding States concerning the public mental health system.

Kaiser Commission and Medicaid Spending

In May of this year, the Kaiser Commission issued a report examining Medicaid enrollment and spending trends. There are several interesting highlights from that report that are noteworthy:

- ✓ During a period from 2000 to 2004, Medicaid spending rose by 12% annually between 2000 and 2002, and then slowed to 7.6% from 2002 to 2004 as the economy improved following the 2001 recession. During this period of Medicaid enrollment growth, states were able to keep increases in health spending per Medicaid enrollee to levels below private insurance. Annual spending growth on medical services fell from 12.9% between 2000 and 2002 to 7.4% in the latest year.
- ✓ Spending per enrollee increased at an average annual rate of 5.2% for the aged and disabled and 5.9% for families from 2000 to 2004.
- ✓ Spending per enrollee grew at an average annual rate of 6.4% for acute care and 4.2% for long term care from 2000 to 2004. Notably, the per-enrollee acute care Medicaid spending growth was well below both the estimated 9.5% average annual increase in health spending for those

  with private coverage. During the same period, private insurance premiums rose by an average

of 12.2%.

- ✓ Increased enrollment was responsible for much of the growth in Medicaid spending from 2000 to 2004. Medicaid enrollment grew primarily due to economic conditions that left more people eligible for the program as their incomes declined and many lost employer sponsored insurance coverage.
- ✓ It is difficult to imagine how Medicaid could have better controlled per capita spending, especially given that Medicaid purchases services in the same market as private insurance plans and kept per enrollee spending growth to levels below those seen in the private market.
- ✓ Approaches to contain costs that impose reductions on eligibility and enrollment or further limit provider payments are likely to lead to both greater increases in the number of uninsured and access to care barriers for Medicaid's low income population.

Comprehensive Neuroscience Project

We support the Comprehensive Neuroscience Project which is a partnership between SRS and Medicaid to review prescribing practices for Medicaid beneficiaries who receive behavioral health medications. The objective is to identify prescribing patterns of physicians outside the national standard guidelines and educating them through a variety of communication media. All changes on the part of the prescribing physician are voluntary. Targeted education and consultation will allow physicians to self-regulate their own prescribing practices once they become fully aware of best-practice standards. This program has been implemented successfully in Missouri and we look forward to enjoying similar successes here in Kansas.

Medicaid State Plan Rewrite

As you know, SRS and Medicaid staff have been working on addressing critical parts of the State's Medicaid Plan requiring revisions to meet the satisfaction of the Centers for Medicare and Medicaid Services (CMS). We support the approach taken and appreciate the recognition by SRS and Medicaid of the value in having the CMHCs retain primary responsibility for meeting the needs of all Kansans accessing the public mental health system. Some of the benefits to this approach include:

- ✓ It is consistent with the values that have guided system partners in developing sturdy community-based services;
- ✓ Preserves current system infrastructures;
- ✓ Develops an integrated and coordinated portal to the public mental health system
- ✓ Increases access to Medicaid for qualified providers through associate agreements
- ✓ It enables the public mental health system is make effective and efficient use of all treatment resources available; and
- ✓ Collaboratively builds the future service system that supports core values of consumer choice and provider access in managed and cost effective ways.

There is much more that could be said about this approach and changes that will impact the public mental health system. However, our message to you today is that we support the approach and look forward to working with SRS, Medicaid and others in the various and multiple opportunities for feedback around implementation along the way.

KHPA Retreat

As part of your retreat this year, you identified planning domains, such as access and coverage, quality and safety, affordability and efficiency, and prevention and health promotion. We believe all of those planning domains are excellent domains to focus on for the future.

You indicated that meaningful health insurance coverage is a powerful indicator of financial access to care. We would ask that as you explore this issue, you include mental health benefits in those discussions. We believe true mental health parity (equal insurance coverage for mental illnesses on par with physical conditions) or at least increased incentives to improve employee benefits for mental health coverage would reduce the possibility of individuals having to rely on Medicaid insurance should they suffer from a mental illness that requires ongoing treatment where insurance does not provide coverage.

With respect to Goal 3 of the access and coverage domain, which is to stabilize and enhance the health care safety net, you emphasized the importance of stabilizing and enhancing the health care safety net which provides care to Kansans with low incomes or those without insurance. We would ask that you include in your considerations Community Mental Health Centers, as they are the safety net for individuals with low incomes and/or those without insurance who seek mental health care.

We support your quality and safety goal #1 which is to use data to drive policy development. Often times we find that policy makers and others rely on anecdotal information to make policy decisions or to influence policy making. We believe there should be an appropriate and effective use and dissemination of health data on which policy decisions can be made.

World Health Organization

It seems appropriate to mention here that The World Health Organization (WHO) estimates the burden of mental disorders will grow in the coming decades. They estimate that by 2020, mental disorders are likely to account for 15 percent of disability-adjusted life-years lost. Depression is expected to become the second most important cause of disability in the world.

We know that treatment works and people can recover from mental illness. We know that psychosocial rehabilitation and family/group interventions in combination with medication can reduce the relapse rates for schizophrenia from 50 percent to 10 percent. We also know that the costs of not treating mental disorders outweigh the costs of treating them.

According to the WHO, there are evidenced-based social, environmental and economic determinants of mental health (see Attachment C). The WHO also goes on to say that individual and family-related risk and protective factors can be biological, emotional, cognitive, behavioral, interpersonal or related to the family context. For example, child abuse and parental mental illness during infancy and early childhood can lead to depression and anxiety later in life as well in next generations. Marital discord can precede conduct problems in children, depression among women and alcohol-related problems in both parents. Elderly people who are physically ill may suffer from a range of subsequent risk factors and problems such as chronic insomnia, alcohol problems, elder abuse, personal loss and bereavement.

Also noted by the WHO are main evidence-based factors that have been found to be related to the onset of mental disorders. Those are also outlined in Attachment C.

The determinants of mental health and those risk factors identified as being related to the onset of mental disorders are things we as a state should continue to pay attention to and focus on in the years to come. I am happy to say that much of what the CMHCs do on a daily basis addresses many of these determinants and risk factors.

Exploring Opportunities for Medicaid Reform

We believe that Medicaid should continue to be the safety net health care program for the most disabled and vulnerable citizens. Medicaid must maintain a robust set of both mandatory and "optional" services to meet the full range of needs of the most disabled and vulnerable. Medicaid services should include an array of supports and services needed to maintain disabled and vulnerable populations within their communities and to avoid over utilization of costly institutional care. We also believe there are some opportunities worthy of consideration:

- Inspector General. We support the concept of an Inspector General for the Medicaid program in Kansas to protect the integrity of Medicaid programs and to have a concerted focus on Medicaid fraud and abuse. We believe this is an important and critical first step in any reform effort in Kansas. We must first ensure the integrity of current programs and eliminate opportunities for fraud before considering cost saving measures such as limiting benefits, restricting eligibility, etc.

- Mental Health Parity and Impact of Mental Health Treatment on Health Care Costs. We believe true mental health parity (equal insurance coverage for mental illnesses on par with physical conditions) or at least increased incentives to improve employee benefits for mental health coverage would reduce the possibility of individuals having to rely on Medicaid insurance should they suffer from a mental illness that requires ongoing treatment where insurance does not provide coverage. Research also shows that there is a decrease in total health care costs following mental health interventions, even when the cost of the intervention is included. For example, a three year study by Aetna showed that the medical costs per beneficiary dropped from $242 per person to $162 in a period of three years after the introduction of mental health services.

- Evidence-Based Practices. We support working with Medicaid to appropriately incentivise the use of evidence-based practices. According to the Institute of Medicine, the lag between discovering effective forms of treatment and incorporating them into routine patient care is unnecessarily long, lasting between 15 and 20 years. With appropriate incentives, we believe that gap can be reduced. With the emergence of EBPs, the CMHCs are committed to a new level of quality and accountability in services and programs. We are implementing the following EBPs: Dartmouth Supported Employment; Dual Diagnosis Integrated Treatment; and Emerging Best Practice of Strengths Based Case Management.

- Expanded Role of Nursing Facilities for Mental Health (NFMHs). We believe there are opportunities to work with NFMHs to supplement acute care psychiatric inpatient resources which would reduce reliance on more costly inpatient care.

- Greater focus on Older Adults. We believe with appropriate funding identified for mental health outreach to older adults, those efforts could lead to reducing the premature admissions to nursing facilities, thus saving Medicaid expenditures for long-term care. Research shows that almost 20% of persons age 55 and over experience specific mental and cognitive disorders that are not part of

the "normal" aging process. Research also shows that older adults with any diagnosed mental illness are about twice as likely to have to move to a higher level of care.

- Encourage Flexibility and Innovation. We believe State Medicaid regulations should be designed in such a manner as to minimize unnecessary administrative costs and encourage innovation and flexibility so as to provide quality, cost effective services in the most efficient manner possible.

Other ideas include:

- Eliminating errors, overuse, rework, inefficient processes and duplication will increase quality and decrease costs.
- Employer mandates and providing financial assistance to workers and employers to afford coverage.
- Pool purchasing power to make coverage more affordable.
- Allowing buy ins for workers.
- Promoting use of health information technology.
- Emphasizing and paying for prevention and early intervention.
- Demonstration projects that reward Medicaid clients for making healthy lifestyle choices and create incentives to be more prudent health care consumers.

Transformation of the Public Mental Health System in Kansas

It is important to note that reform themes in overall health system, such as care coordination, information technology, pay for performance and consumer-driven care are themes that are encompassed in transformation themes currently underway in the Kansas public mental health system.

By Executive Order of Governor Sebelius, Executive Order No. 04-10, issued on September 22, 2004, the Governor's Mental Health Services Planning Council (GMHSPC) is directed to coordinate New Freedom Commission-related recommendations from stakeholders, consumers, mental health service providers, community services providers and others, and based thereon, make appropriate recommendations to the Governor; and to work with the State Mental Health Authority; as well as other State departments, to improve and refine the State's mental health strategic plan and develop strategies to improve mental health services across all systems and State departments.

Pursuant to the Executive Order, the Transformation Subcommittee (TSC) of the Governor's Mental Health Services Planning Council was created. Dr. Jane Adams, Executive Director of Keys for Networking and also a Commissioner on the President's New Freedom Commission; and Mike Hammond, Executive Director of the Association of Community Mental Health Centers of Kansas, Inc, serve as the Co-Chairs of this Subcommittee. The primary work product of the TSC has been the development and continual adopting of a Transformation Grid consisting of themes and tasks (see Attachment D). This Grid has been presented to the GMHSPC Subcommittees to move these themes and tasks from the Grid into their respective work. It is an action agenda in progress.

Concerns Moving Forward

- We are concerned about the impact of Presumptive Disability on the mentally ill who are currently receiving services through the MediKan program. As you know, if a MediKan client is not presumed disabled through the review process and have exhausted all Social Security

Administration appeals, they will no longer receive medical benefits. That leaves those MediKan clients currently served by the CMHCs without any resources. Due to a current state mandate that CMHCs serve everyone who walks through our doors, this means additional strain on already strained resources. This is a concern shared by key legislators and those concerns were voiced during the 2006 Legislature. We hope there will be opportunities this summer and fall to work with the Authority staff to examine viable options so that resources are made available to address this concern.

- We are concerned about the impact of the Deficit Reduction Act (DRA) on the citizens of Kansas who rely on Medicaid. The DRA provisions either require mandatory changes in state Medicaid programs or add to the myriad of options already available to states in the Administration of their programs. We have not heard from Medicaid as to the outcome of their process in evaluating those provisions and what impact those will have on Kansas.

- We are concerned about employer insurance coverage eroding; personal incomes continue to shift downward; the impact of Medicaid changes at the federal level; rising insurance premiums; and limited resources. An equally important concern we share with others is that there is no consensus on reform strategies.

- We do understand that the legislative timeline of January 2007 is a point in which the KHPA could make a decision about including or excluding Home and Community-Based Services (HCBS), Targeted Case Management (TCM), Mental Health, Nursing Facilities for the Mental Health (NFMHs), Nursing Facilities (NFs), Substance Abuse (SA), and State Hospitals under the KHPA. If all were to move, it would mean an additional $1.1 billion in expenditures overseen by the KHPA. Because the KHPA assumed those programs under the direction of the Division of Health Policy and Finance (DHPF) effective July 1, 2006, which includes Medicaid, we believe the January 2007 timeline for considering other programs under the KHPA is too ambitious. We believe the challenges of the current programs under the authority of the KHPA are challenges that will warrant significant time of the Authority and its resources that assuming any new programs would not serve the best interest of those programs, the consumers and families impacted or providers. Therefore, we are recommending that the KHPA request to the 2007 Legislature a delay in any considerations of expansion until at least January 2008. As of today, both the Association and the Transformation Subcommittee do not support moving mental health from SRS to the KHPA.

Whatever direction you take in forging forward with your responsibilities to reform health care in Kansas, we urge you to make sure it is a collaborative effort that includes: State agencies, the public, employers, insurers, providers, advocates, pharmaceutical companies, and most importantly, the consumers of services.

Thank you for the opportunity to appear before you today.

ATTACHMENT A

CMHC System Snapshot

CMHCs Role in the Public Mental Health System

There are 29 licensed Community Mental Health Centers (CMHCs) in the State of Kansas. Each CMHC has a defined and discrete geographical service area. With a collective staff of over 4,000 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. Together, this system of 29 licensed CMHCs form an integral part of the total mental health system in Kansas.

As part of licensing regulations, CMHCs are required to provide services to all Kansans needing them, regardless of their ability to pay. This makes the community mental health system the "safety net" for Kansans with mental health needs – both target and non-target populations. The target population consists of adults who have a severe and persistent mental illness (SPMI) and children/adolescents who have a serious emotional disturbance (SED). The non-target population is basically everyone else is served by the CMHC.

We are a system that is not self contained, but rather one that crosses boundaries. For example, the correctional system is one that if you haven't broken the law, you don't get in their system. For community mental health, there aren't any boundaries. Literally every other human service system recognizes the need for mental health services. The CMHCs integrate and collaborate with systems such as education (regular education and special education), juvenile justice, developmental disabilities, corrections, aging, child welfare, general medicine, law enforcement, and many more.

As the local Mental Health Authorities for community-based mental health services in Kansas, CMHCs provide the primary linkages between and among service agencies as well as transitioning consumers from child to adult services. The CMHCs serve as the gatekeepers to state mental health hospital treatment by screening all referrals to state hospitals. Also, to ensure necessary linkages with community supports, mental health reform legislation mandates "that no patient shall be discharged from a state hospitals if there is a participating mental health center serving the area where the patient intends to reside, without receiving recommendations from such participating mental health center." Each CMHC has one or more liaisons who go to the state hospitals to assist with discharge and aftercare plans, as well as coordinating with private psychiatric facilities and nursing facilities for mental health (NFMHs).

In addition to prior mental health reform initiatives that were primarily targeted to state hospital usage, gatekeeping procedures have been established for admitting Medicaid recipients (or those believed to be eligible for a Medical card) to general psychiatric units in the community. Medicaid recipients who are candidates for inpatient psychiatric treatment must first be screened (assessed for medical necessity) by the local CMHC under contract with The Consortium. The purpose of pre-admission screening is to assure the individual is in need of the intensity of services provided by an acute care hospital, or whether they could more appropriately be served in the community.

The primary goal of CMHCs is to provide quality care, treatment and rehabilitation to individuals through mental health programs in the least restrictive environment. The CMHCs strongly endorse

treatment at the community level in order to allow individuals to keep functioning in their own homes and communities at a considerably reduced cost to them, third-party payers, and the taxpayer.

Primary Goal of CMHCs

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Shared Governance – A Partnership Between State and Local Government

Most Kansans are probably unaware that county government is the cornerstone of the Kansas public mental health system. In 1962, the Kansas Legislature passed the Community Mental Health Centers Act. This Act provided for the establishment and governance on county government. The Mental Health Reform Act of 1990 reaffirmed the principles and values of a locally controlled mental health system.

A CMHC can only be created by action of the Board of County Commissioners. County government serves two principal roles with respect to CMHCs: determining and establishing the governing structure for CMHCs; and providing county financial support for CMHCs.

The CMHCs also have a partnership with state government. Among the state's role in the public mental health system is licensure of CMHCs, contracting with CMHCs for services, statewide oversight and focus on target populations.

Accountability

First and foremost, CMHCs, through their County Commission authorized boards, are accountable to the public mental health interest. The CMHCs are further accountable to federal, state and local governments. Some examples include: CMHC licensing rules and regulations; participating CMHC contracts with SRS; Medicare and Medicaid rules and regulations; Mental Health Field Staff; and other periodic audits and studies on CMHC functioning.

Father down in this document, you will see the outcomes we are producing in delivering community-based services, as well as the consumer and family satisfaction levels.

Services to Adults with Severe and Persistent Mental Illness (SPMI)

A major accomplishment of the Mental Health Reform Act of 1990 was the development and enhancement of community based services for the adult target population. Community Support Services (CSS) refers to the array of community based services that are provided to the adult targeted population, which consists of individuals who suffer with a severe and persistent mental illness (SPMI). A severe and persistent mental illness refers to a biological brain disorder, such as schizophrenia, that impairs an individual's ability to function throughout their life. However, individuals with severe mental illnesses that were once considered to be marked by lifelong deterioration are now energized by the message of hope and recovery offered by CSS programs.

The guiding philosophy of CSS programs are embodied in the work with consumers in promoting recovery and achieving their self-defined goals. The CSS model emphasizes using an individual's strengths, desires and aspirations to support and teach the skills individuals needs to be successful in the living, learning, working and social environments they choose. Community Support Service programs across the state provide a broad spectrum of services and activities to support some of the most at risk and vulnerable citizens of Kansas that suffer with a severe and persistent mental illness. These programs are built upon a case management model that promotes recovery and focuses on assisting consumers to live successfully in the community.

Every individual served through a CSS program have access to case management services as well as psychosocial services, vocational services, attendant care services and medication management, if they desire it. All of these services facilitate the treatment process through direct interactions that assist consumers in understanding their symptoms and teach community living skills. Beyond focusing on symptoms management, recovery casts a much wider spotlight on quality of life, restoration of self-esteem and on attaining meaningful roles in society.

Kansas is a leader in the area of community mental health for the adult target population. Across the state model programs are being developed utilizing best practices in areas such as Supported Employment, Supported Education, Dual Recovery and Supported Housing. The successes of these programs are not only found in the improved quality of life but in the performance outcomes that are produced statewide, as outlined below.

Outcome	FY89	FY06 (Q1)
Living Independently	47%	91%
Competitively Employed	18%	20%
Participating in Some Form of Educational Activity	2%	4%

Services to Children/Adolescents with Serious Emotional Disturbance (SED)

Community Based Services (CBS) programs serve children and youth who have been identified as having a SED and have demonstrated a need for interventions other than traditional outpatient mental health care. A fundamental goal of CBS is to help at risk children and youth remain in their home, school, and community. To help achieve this goal, children and their families may receive an array of individualized services and support. Strength based, family focused and family driven, culturally competent, and community-based are the core values that drive CBS programs.

To be identified as having a SED, a child or youth must have a diagnosable mental, behavioral, or emotional disorder and exhibit a functional impairment in their home, school, or community. Common diagnoses associated with SED youth include: Attention Deficit/Hyperactivity Disorder or ADHD, Bipolar Disorder, Depression, and Oppositional Defiant Disorder. A developmental disorder such as Autism, mental retardation, or a substance abuse disorder would not on their own meet the criteria for SED. Although these disorders may co-exist with a mental health disorder.

Children and youth with SED often become easily frustrated and may have great difficulty following rules at home. Because of their poor ability to understand and express their feelings appropriately, these children may become verbally or physically aggressive towards siblings or even parents. Other children may be more isolative, attempt to hurt themselves, or try to commit suicide. Parents may

describe that their child is out of their control, feel powerless to help their child, and may be ready to turn their child over to someone who can help them such as a hospital or residential treatment facility.

At school many children with SED are known by every teacher, school administrator, student, and their parents for all the wrong reasons. These are the children who have trouble sitting in their desks and paying attention. They may annoy other students and have great difficulty making friends. They may be verbally inappropriate or aggressive, and may become physically aggressive or destructive to property when challenged. Children with SED who act out in these ways are frequently suspended and often are failing in school because of their mental health disorder. Other children who experience depression or anxiety may be quiet and almost invisible to teachers or go to great lengths to avoid school. These students also may be unsuccessful at school academically or socially. Children with SED are often referred for Special Education services, medication or other mental health services.

Children and youth with SED may experience difficulty functioning in the community as well. Participation in community activities such as sports, boy scouts, girl scouts, or other peer-related activities may be difficult due to poor social and coping skills, and they may be expelled from such programs. Finding daycare equipped to manage their behavior is also a challenge for parents. It is not uncommon for parents of children with SED to face having to quit their job due to the lack of appropriate daycare or because of frequent request from the school to come get their child. For other children, their behavior may bring them into contact with law enforcement. Schools and even parents may call police for a child who is "out of control." Assault, destruction of property, or disorderly conduct charges may be filed against the child.
In past years many children with SED were hospitalized sometimes for years or may have been placed in a residential treatment facility. Now, with services and supports through CBS programs, children usually remain at home with their families and attend school with their peers. When hospitalization is needed, it is most often very short term.

The core service of CBS is **Case Management**. Case managers are responsible for the development of goals, overall coordination of services and treatment for their clients, and help locate and acquire community resources. They coordinate services with schools, attend school meetings with the child and parents, and provide information and education about the child and his/her disorder. Case managers may also provide parents with education on parenting and mental health disorders, and offer caregivers encouragement and support. If a child is hospitalized, the case manager will work with hospital staff to ensure services are in place following discharge. These types of activities are considered to be Targeted Case Management
(TCM).
Case managers also work one on one with children to help them develop skills needed to manage their behavior and other symptoms of their disorder. Problem solving, anger management, and social skills are only some of the skills case managers teach their clients. Case managers also work with caregivers and help them develop behavior plans and other strategies to manage their child's symptoms and to ensure safety in the home. Responding to crisis at home or school and helping de-escalate a child is also a responsibility of a case manager, as well as helping families develop crisis plans and strategies. Services involving direct intervention with the child present are considered to Community Psychiatric Support Treatment (CPST).

Attendant Care is defined as a one on one support and supervision with children to accomplish activities of daily living, and providing support to the individual and/or family in maintaining daily routines. Specific skills may be targeted and practiced with the child or youth such as following an

anger management program, or attendant care may be used to help a child participate in recreational activities or follow daily routines at home. Services may also be provided at school to assist the child in managing their behavior or other mental health symptoms. Attendant care is used to help support and stabilize a child in a crisis as well.

Wraparound is a service that brings together professional and natural family supports to create a child and family team and develop an overall treatment plan for a child. Through wraparound, case management and other professional services may be arranged but also natural supports, such as uncles, grandparents, ministers, and even school janitors, may be identified to support and work with the child and family. Wraparounds are always strength based and use the strengths of the child and family team to develop interventions.

Home Based Family Therapy is provided by a licensed clinician and works with the family to establish healthy rules and consequences, establish appropriate boundaries, develop positive communication skills, and develop strategies to improve the child's and family's functioning. By providing services in the family's home, the environment can used to help assess the family needs and be a vital part of the interventions that are developed.

Psychosocial Groups is a goal directed group aimed at assisting children with daily problem solving, improving social skills, promoting health, and enhancing personal relationships. Groups are provided in a variety of settings at different mental health centers across Kansas. Most common groups are after school programs in which children attend group from one to five days a week, depending on the program. Other CMHCs have partnerships with school districts to provide psychosocial groups during the school day in which students are pulled out of class to participate. Psychosocial groups allow children with SED to socialize, learn new skills, and participate in activities they otherwise may not be able to experience.

Parent Support Services are provided by parents who know first hand what it is like to parent a child with SED. Often the most trusted CMHC staff by families, parent support workers relate in a personal way that case managers, therapist, and other professionals cannot. Parent support staff are available and focus on the support to parents, while helping them through crisis, attending Individual Education Plan (IEP) meetings, or helping prepare them for court. Some parent support staff also assist with providing parent education or facilitating parent support groups.

In a few areas of the state, **therapeutic preschools** provide daily psychosocial groups, case management, and home based family therapy to children two to five years of age. Early identification of these children provides an opportunity to help the child develop the skills necessary to be successful in school and parents to develop strategies and interventions to help their child. Most therapeutic preschool programs are funded through state grants.

Other areas in the state offer **school based mental health programs or day treatment programs.** Combining educational staff and mental health staff, these programs are designed to meet the therapeutic and academic needs of the child. Case management, individual therapy, and psychosocial groups are built into the daily routine. School based mental health programs targets children whose mental health needs severely impair their ability to be successful in school and require intensive full day treatment, and is typically only tried after other efforts have failed.

Respite Care is available for families needing separation from each other as a "cool down" time due

to family/child conflict or other crisis, but may also be used to relieve parents from the stress of raising a child with a SED. Currently, payment to CMHCs for these services is only available for families receiving the SED Waiver.

Finally, we are very proud of the outcomes we have seen for services to this population, as outlined below.

SED Children/Adolescents Receiving Case Management

Outcome	FY97	FY06 (Q1)
Permanent Home	75%	93%
A, B, or C Grades	66%	73%
No Law Enforcement Contract	69%	92%

Beginning in January, 2005, school attendance was measured not as regular attendance as it has been measured in the past, but as a number of excused and unexcused absences. For FY06 (Q1), 87.5% had 0 to 2 absences, compared to 76.3% in FY05(Q4).

Children/Adolescents Served on the HCBS/SED Waiver

Outcome	FY97	FY06 (Q1)
Permanent Home	92%	97%
A, B, or C Grades	75%	75%
No Law Enforcement Contract	87%	93%

Beginning in January, 2005, school attendance was measured not as regular attendance as it has been measured in the past, but as a number of excused and unexcused absences. For FY06 (Q1), 85.6% had 0 to 2 absences, compared to 70.7% in FY05(Q4).

It is important to also note highlights of the findings of an independent evaluation of the HCBS/SED Waiver conducted in 2005:

- ✓ With regard to access to care, findings indicated that the target population is being served under the Waiver per its intent. The children's access to community-based services that maintain them in the community is supported by their outcomes.
- ✓ During focus groups, parents unanimously expressed a desire to maintain their children in the home and community rather than have them hospitalized and they credited CMHCs for helping achieve this desire.
- ✓ With regard to quality of care, findings of this study indicate that children served by the Waiver are receiving high quality care. Services were found to me strengths-based, family-centered, and delivered through a wraparound model.
- ✓ In focus groups, parents spoke poignantly about the helpfulness and quality of services covered by the Waiver that were received at the CMHCs.

SED Youth Who Are Transition Age – 16 Years of Age and Over

Outcome	FY06 (Q1)
Permanent Home	88%

A, B, or C Grades	67%
No Law Enforcement Contract	83%

Outcomes for SED Children in SRS Custody and those in JJA Custody; FY06 (Q1).

Custody Status	Living in Family Home Setting	No Law Enforcement Contact	Regular Classroom Setting (no support) and those with support)	A, B, or C Grades	School Attendance (0 to 2 absences)
SRS	94%	88%	80%	70%	90%
JJA	83%	71%	66%	53%	85%

Crisis and Emergency Services

In response to growing concern about the availability of crisis and emergency services, SRS began to explore ways to improve the crisis and emergency services system in Kansas. The Department of SRS commissioned a study in order to clearly identify core issues and to help establish priorities for improvement. What has subsequently resulted is the development of crisis plans for each CMHC.

Throughout the state, minimal expectations include the following:

- CMHCs will make crisis case management services available to individuals who have received a screening and have been diverted from hospitalization; and
- Individuals in crisis will receive assistance to remain safely and successfully in their home and community.

Specifically, CMHCs are required to:

- Increase medical services that assist individuals in managing psychiatric medications.
- Add hours of attendant care and case management for adults with SPMI and children with SED.
- Provide evening and weekend case management, in-home family therapy and attendant care.
- Improve crisis services to children by insuring that staff with expertise is available 24 hours a day.

Each CMHC catchment area utilizes a committee comprised of stakeholders and community partners to review, monitor and refine the goals and objectives of the Crisis Plan.

There menu of services includes five levels of a Continuum of Crisis and Emergency Services, from least to most restrictive. Each CMHC offers different services and different versions of the some of the same services

Services to Non-Target Populations

The non-targeted population is another name for individuals like you and me who encounter problems as we move through life but who continue to function for the most part, not impaired and challenged

by a brain disorder or mental illness.

While the community mental health system has developed expertise in working with individuals with a severe mental illness, we also see many more individuals each day in our communities who are struggling with issues such as anxiety and depression, reactions to job losses, deaths of those close to us and problems with addictions of all sorts.

Community mental health centers in the state have developed a wide range of services to help individuals with these presenting problems. We believe that if left unaddressed, they have the potential to escalate to more serious problems and eventually have the potential to affect daily functioning. The services most utilized with this population are services we refer to as traditional services. They include services that one usually thinks about when hearing that individuals are seeking help. They include services such as individual and group therapies, medication evaluation and management for those who need some chemical assistance to reduce symptoms and crisis intervention work for those individuals who find themselves in a situation that is overwhelming to them.

As you have heard, each CMHC contracted several years ago with SRS to identify some strategies where crisis services could be more immediate, responsive and comprehensive. All CMHCs developed a list of gaps in services as well as a list of crisis services that were working well. As a result, all CMHCs developed crisis plans that increased the array of services being offered.
Each CMHC has a unique relationship with their community or service area and have designed services that specifically address that community's needs.
In addition, over half of the CMHCs in the state provide addiction treatment services to individuals with a substance abuse or substance dependence problem. These services can address both problems with alcohol and with street or prescribed drugs.

Every CMHC also has a wide array of outpatient services or therapy services available to those who need more help that than offered during a crisis. A number of individuals who no longer need to have the level of services offered by our Community Support Services to the targeted population are seen for some sustained help and medication management in our Out-Patient Services programs.

Consumer Satisfaction Levels Are High

91% of youth report satisfaction with trust in CMHC staff.
90% of youth report satisfaction with how quickly they received help.
95% of youth report overall satisfaction with CMHC services.
92% of parents report overall satisfaction with CMHC services.
93% of families report satisfaction with level of participation in treatment planning.
93% of families report satisfaction with the time between first call and intake at the CMHC.
90% of families report satisfaction with time between intake and first appointment.
90% of adults report satisfaction with CMHC staff performance.
86% of adults report satisfaction with service quality.
82% of adults report satisfaction with the choices they had.
80% of adults report satisfaction with the level of access to CMHC services.

Source: 2004 Kansas Family Satisfaction Survey and Kansas Youth Satisfaction Survey; 2004 Adult Satisfaction Survey

ATTACHMENT B

Heather

Four County Mental Health, Independence, KS

I have been a foster parent for over eight years, and have seen many changes within the system. One change that I feel has been very positive is the services from the community based mental health centers. Foster children typically feel over controlled and under valued by a perceived uncaring "system." In the past, it has been a case manager from the child placement agency that would make the decision for the child's care, these managers typically see the kids on their caseload once a month or less.

Many times, a child in my care would question someone who truly did not know them, but made decisions about their future. With wraparound services from Four County MHC in our area, these children have relationships with their case managers and attendant care workers. They form peer relationships within the psychosocial groups and the CMHC. They have strong support from many different professionals who collaborate with them and their foster parents to develop appropriate and achievable goals.

When a child has this wonderful support system, they gain confidence in themselves and in others where before they had little. They feel supported in all aspects of their lives and tend to build on these successes. I have seen such improvement in attitude and confidence, grades and daily living sills. The children feel more in control of their future when they are active participants in setting goals. I believe the community mental health system is an invaluable resource. The children are connected to the community through the CMHC and in return feel as though they belong to their community. With the losses these children tend to suffer--in their family and extended family--any positive, caring support they can receive is important to their growth.

Ben

ComCare, Wichita, KS

During my youth, I had little self confidence because of family divorce and instability. Depression and isolation lead to thoughts of suicide throughout my teen years, and at 21, after being laid off, I began seriously contemplating ending my life. I chose to become highly intoxicated and lay on the railroad tracks. I woke up in the hospital and discovered that God had spared my life, despite the fact I had lost my left hand. Miracles do happen! When a train runs over someone what would you say the chances are that they survive? That is the miracle in my story.

I have overcome suicide, and am in continual recovery from alcohol abuse, survived my parents and my own divorce and live with severe depression today. All this would swallow me up if I hadn't had a simple faith in God and been able to receive 11 months of rehabilitation and hospitalization. This led me to the doors of Breakthrough Club of Sedgwick County, and also ComCare in Wichita, Kansas. Despite having only one hand, I did not allow anything to get in my way of starting a new life. At Breakthrough Club, I discovered new abilities and talents. I helped begin the Transitional Age Program for youth who are diagnosed with mental illness, ages 14-24. After 11 years of participation in the Clubhouse, I was hired as a staff member and am now grateful to be giving back what I received from Breakthrough Club.

I am now able to do the things I enjoyed in high school--singing, writing, speaking became the main gifts I started to believe I could do well. The staff at Breakthrough, fellow alcoholics and friends and family everywhere encouraged me and helped me to gain confidence in myself. Medication, physical and psychological therapy, AA meetings, prayer

and for the first time real authentic friends helped me to see I had value and a purpose. I now have goals of returning to college and this past September I ran in a 3.2 mile event and surpassed my time goal by 1 1/2 minutes.

Thank you for letting me tell my story to you. I would appreciate it and so would my colleagues if you would continue to push hard for those who are often looked over because of the public's stigma about mental illness. We want to return to work and school, and be a vital member of our cities and state. We hope for an adequate and safe place to live that we can afford, and to be able to pay for rent, utility bills, food, medication and other basic needs met. We can recover and focus on what everyone who is considered normal has--family, work and education. I would like to leave you with a quote: "It's not about thinking less of yourself but thinking of yourself less." Again thank you for you ear and time.

Debby
The Guidance Center
Leavenworth. KS

My life has been one of much emotional pain and shame, drug and alcohol abuse, self-mutilation, called cutting, enormous weight losses and gains, and two suicide attempts. The good news is—I'm still here to tell about it.

I am 53 years old. I am a teacher. I am bipolar. I have been in and out of therapy, more in than out, for 30 years. I currently see a psychiatrist at The Guidance Center in Atchison for medication, which I now only take as needed. I am also in individual therapy with a private psychologist.

I was raped when I was nine by someone I loved and trusted. That was the beginning of my journey into and out of the years of fighting to survive while fighting just as hard to die. I couldn't make up my mind.

I had two significant suicide attempts. I didn't even realize how serious they were until I began to get better and to look back on them. It is by the intervention of Kate Werring, then a therapist at The Guidance Center in Leavenworth, Kansas, that I survived the first attempt, which was a drug overdose, and began to discover the details of my past.

The second attempt I survived because I finally made up my mind to survive. I had cut my wrist into the artery and I knew that if I waited long enough I would die. But when the reality of death was present, I realized while I would do almost anything to make the emotional pain stop, killing myself was no longer one of those things. My world changed that day.

It took three very, very difficult years after that awakening, years of intense in and outpatient therapy, numerous medications and a whole lot of tears. But, because The Guidance Center's therapists had laid the foundation for my recovery and all the mental health professionals I encountered along the way stuck with me through all the drama, game playing and the realities of my illness, I am here today. I rejoice in the fact that while to quote Langston Hughes, "life for me ain't been no crystal stair," it has been an adventure that has helped me become a much kinder, gentler person. I am so grateful that there are people like those at The Guidance Center, without them, I would not be here. I could not have saved myself without help. I did not have the knowledge, the tools, or the economic means to do so.

It is 12 years since my final suicide attempt and I continue to struggle at times but I am no longer suicidal, or cutting, or drinking and drugging. I have lost 95 pounds, I have become a good teacher and employee and I am happy most of the time. But most importantly, I no longer feel ashamed and I am alive and now, I know what a good thing that can be.

My mental illness is a battle for me that never ends, I feel some form of it each day, but as long as there are good mental health facilities and good mental health professionals like those I have encountered along the way, it is a battle I do not fight alone. It is a battle that little by little, day by day, I win.

Thank you for funding community mental health services, such as those I receive at The Guidance Center.

Pamela
Johnson County Mental Health

I want to start this story by telling you that my grandchildren, now six, seven and almost nine years of age, began their lives in darkness, hopelessness, homelessness, terror and severe neglect. In June of 2004, I adopted my three grandchildren.

They were first placed with me in January of 2001. In 2002, I had a life threatening surgery that required several months of recovery. As a result, my grandchildren were placed in a foster home for several months. After learning my grandchildren were not being properly cared for, the Judge involved in their case ordered their immediate removal from the foster home in which they were residing. Although I had still not fully recovered from surgery and wasn't certain I would be able to meet all of their needs, I desperately wanted to take them into my home again. During the time the social workers were removing my grandchildren from their foster home, I drove directly from the courthouse to Heartland Learning Center to inquire about Head Start.

Once at Heartland Learning Center, I explained that my three children had very serious behavioral and emotional problems. The oldest child was in a world of his own and severely delayed. The seven year old had uncontrollable temper tantrums which often led to her being a danger to herself and others. The six year old was following right behind her sister and was experiencing night terrors. Not only did my grandchildren desperately need help, but I did as well.

Helen Imel, at Heartland, said to me "I can help." Helen informed me about a wonderful new program called "Step Ahead". The two younger children, both girls, were enrolled almost immediately. Helen also advised me of other programs and services that might be available to my grandchildren and me through Johnson County Mental Health Center. As my grandchildren and I became involved in services at Johnson County Mental Health Center, things began to change for the better. I was surrounded by people who helped and supported not only my grandchildren, but also myself. The people from Step Ahead, our in-home family therapist, and case managers knew in a short time more about my grandchildren's behaviors that I did. They were able to help teach my grandchildren about choices and consequences as well as techniques to calm themselves. I learned how to respond to and help my grandchildren with their behaviors and emotions. Additionally, I was given ideas on how I could make my own life less chaotic. They provided us with the skills we needed to survive.

If you believe in God, then I know you will believe that Helen was waiting for me at Heartland Learning Center on December 16, 2002. I honestly have no idea where we would be without the Step Ahead Program and other services provided to us on behalf of Johnson County Mental Health and their Family Focus Program. What I do know is that we could have never made it this far.

Coleen and McKenzie
High Plains Mental Health
Hays, KS

Hello, my name is Coleen. My hopes are that my personal testimony will help illustrate the importance of community based services for children with mental illnesses. My youngest daughter was born April 30, 1996. She was adopted as an infant and was judged "healthy" outside of some initial blood irregularities – sodium, potassium, billirubin count, etc. And she had an eye infection. By the end of her first month, she'd had stomach surgery at Children's Mercy in Kansas City. By the middle of that summer, because of fears of some blindness, she was again examined at Children's and was found to have a rare brain disorder called Septo Optic Dysplasia. Her low vision was not caused by problems with her eyes, but by underdeveloped optic nerves as well as underdevelopment of the functions of her mid-brain which controls the thyroid, growth, and other hormones. She received child development services immediately, which greatly contributed to her ability to attend Head Start, kindergarten and now grade school.

We first began having problems with her behaviors in Head Start. In spite of her health issues, to see her, most people consider her "normal". They have no idea of the magnitude of problems she has compensated for. She reads large print as well as Braille and spends some time in the third grade classroom, but mainly in the Resource Room. Her behaviors are a result of some genetic makeup, but largely the imbalance of mood chemicals which have taken years to identify and treat, starting when she was about eight months old. Because these medical problems are invisible to most people, they don't understand the complexity of just dealing with the day to day situations.

By the end of the second year in Head Start, it became apparent to her teachers that McKenzie's hyper-activity, outbursts and oppositional behaviors were not phased by normal behavior plans. By her first grade year, her anxieties became more pronounced and it became harder to contain her within a classroom. After an evaluation at Children's Hospital in Denver, we began therapy at High Plains Mental Health Center. By early winter, she was moved to a remote classroom with the promise of helping her learn appropriate classroom behavior and ultimately return her to the regular classroom. Until that time I had no idea of the degree of distress she displayed at school, which was in turn viewed as "non-compliance".

We now have a case manager through High Plains Mental Health Center who can monitor McKenzie at home and at school to help be a liaison for McKenzie and her therapist. I work full time, so I cannot be there at school to help her educators understand these behaviors and origins. Hers is such a complex case that it takes several professionals to determine what are normal misbehaviors and what are a result of the "glitches" in her brain. Either way, discipline is crucial, and High Plains has been a life saver in helping to educate her teachers in how to approach this.

McKenzie's health issues are also complicated. That summer after first grade, with the help of her psychiatrist and therapist, we got her medications under control, and she attended the summer camp, which is for kids receiving therapy through High Plains. Part of "camp" can even include relaxation exercises the children can use themselves. By the end of the summer she walked into the school with all the other kids and had a successful second grade year. That could only have been accomplished by close communication between the school and High Plains, and her case manager has been crucial to that communication. She attends IEP's and sees McKenzie every other week on a very personal level. Sometimes her case manager attends therapy sessions with McKenzie and me as well. The monetary help with her medications through this program is invaluable to us. Thank you for your continued

support of community based mental health services for children. With the help from High Plains, I have no doubt she will live a successful, independent life as an adult.

JACK

Mental Health Association of South Central Kansas, Wichita, KS

My name is Jack. I am an 8 year old boy. I live in Wichita with my grandma, grandpa, step-mom, sister, and uncle. My grandma and grandpa take care of me the most. Some people even think my grandma is my mom. I don't know my real parents. They left me a long time ago. I don't really know why. I like to ride bikes and go fishing. I am a 3rd grader at Griffenstein Day School. It's a special school that kids go to when they have a hard time controlling their anger or paying attention in a public school. Before I went to Griffenstein I used to kick and hit my teachers and friends. I didn't mean to, but I just got mad and had a hard time controlling myself. I do better at Griffenstein, but some days I still have a hard time controlling my anger. Sometimes I get so mad I even kick the teacher or kids at Griffenstein and tell them that I'm going to kill them with a knife. When this happens I have to go to a crisis place. My grandma or case manager takes me. Sometimes even my grandma is too scared to be around me and she will ask my case manager to take me to crisis. Sometimes the crisis people tell my grandma that I am better and can go home, and sometimes they tell her I have to go to the hospital. I have been to the hospital lots of times. I have been to a hospital called Prairie View. It's the closest hospital to my house. Sometimes if Prairie View is full of other kids like me and they don't have any room left, they send me to KU Medical Center in Kansas City. I get to go home from these hospitals after about 5 days because by that time they think I'll be safe to be around. I have been either to Prairie View or KU Medical Center 12 times. This started happening when I was 3 years old. One time Prairie View told my grandma that I needed to stay longer than 5 days because they were still worried I might hurt someone or myself so they sent me to Rainbows State Hospital in Kansas City. One time my doctor had me go to a Level 6 treatment place. I told the doctor in his office that I was going to jump out his window. He thought this would be the best place for me to stay safe and talk to a lot of people who could help me every day for a couple of months. I like to be at home instead of the hospitals. My grandma has me working with a lot of people that can help me try to stay out of the hospital. I have a case manager, 2 attendant care workers, and an attendant care worker also gets to go with me to psychosocial groups and to school. I have this special person help me when I'm around other kids my age so everyone can stay safe. Sometimes when I'm around other kids I start feeling real nervous inside and want to run away or attack grown ups or other kids. My attendant care worker helps me with these feelings inside so I don't hurt other people or throw things like trash cans. Sometimes I don't want to go with

attendant care workers or psychosocial workers. I have jumped out of a car and tried to jump out of a van one time because I wanted to go back home. I also have a lot of therapy. I go to a therapist I have all to myself to work on anger. My family also has a family therapist that comes to my home and my whole family meets together for this. My grandma also has a special person she can talk to called a Family Service worker. I like these people that work with me and my family, but I hope someday I will have more time to go fishing and ride my bike.

ATTACHMENT C

Evidenced-based Social, Environmental and Economic Determinants of Mental Health

Risk Factors	Protective Factors
Access to drugs and alcohol	Empowerment
Displacement	Ethnic minorities integration
Isolation and alienation	Positive interpersonal interactions
Lack of education, transportation and housing	Social participation
Peer rejection	Social responsibility and tolerance
Poor social circumstances	Social services
Poor nutrition	Social support and community networks
Poverty	
Discrimination	
Social disadvantage	
Violence	
Work stress	
Unemployment	Source: World Health Organization

Evidence-based Factors Related to the Onset of Mental Disorders

Risk Factors	Protective Factors
Academic failure	Ability to cope with stress
Attention deficits	Adaptability
Caring for chronically ill patients	Autonomy
Child abuse/neglect	Early cognitive stimulation
Chronic insomnia	Exercise
Chronic pain	Feelings of security
Communication deviance	Good parenting
Early pregnancies	Literacy
Elder abuse	Positive attachment and early bonding
Emotional immaturity	Positive parent-child interaction
Excessive substance abuse	Problem-solving skills
Exposure to aggression and violence	Pro-social behavior
Family conflict	Self-esteem
Loneliness	Skills for life
Low birth weight	Social and conflict management skills
Low social class	Socioemotional growth
Medical illness	Stress management
Neurochemical imbalance	Social support
Parental mental illness	
Personal loss	
Poor work skills	Source: World Health Organization
Stressful live events	

ATTACHMENT C

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